DEPARTMENT O[illegible]H AND HUMAN SERVICES
HEALTH CARE F[illegible] ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 4

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 405

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 230,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B
#2.b., Pages 1-8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B
Page 2B

10. SUBJECT OF AMENDMENT:
Rural Health Clinic Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:
03/28/01

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
6th Floor, DSOB
915 SW Harrison
Topeka, KS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/29/01

18. DATE APPROVED:
JUN 27 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-01

20. SIGNATURE OF REGIONAL OFFICIAL:
Brenda Gruber for

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
[illegible]

FORM HCFA-179 (07-92)

Instructions on Back

"Substitute per letter dated 6/20/01"

KANSAS MEDICAID STATE PLAN

Methods & Standards for Establishing Payment Rates

Rural Health Clinic Services

Effective January 1, 2001, rural health clinics enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. A RHC will be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare shall be made through an all-inclusive encounter rate determined by the Medicare intermediary for each qualified encounter.

When a rural health clinic furnishes "other ambulatory services", the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all the requirements under the state plan are met. "Other ambulatory services" are those services which do not meet the Medicare definition of rural health clinic services, but are covered under the Medicaid state plan.

1. ENCOUNTER BILLING

    1. Billable Visit or Encounter
    A rural health clinic "visit" means a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health care professional or multiple encounters with the same health professional on the same day shall constitute a single visit.

    2. More Than One Encounter on the Same Day
    If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional RHC visit.

    3. Health Care Professional Requirement
    A visit shall qualify for encounter payment only if the certified professional is:
        1. employed by the rural health clinic; or
        2. under arrangement to receive compensation from the clinic for providing covered services; or
        3. an owner of the RHC. This criteria only applies to a physician, PA, and ARNP.

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4. Place of Service Criteria
   1. **Services at the Clinic:** Covered services provided at the clinic facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as RHC visits. Services performed in the clinic are payable only to the clinic. Practitioners may not bill for these services under any other Medicaid provider number.
   1. Services Away from the Clinic: Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an RHC practitioner excluding visiting nurse may be billed as a visit only if the practitioner is employed or compensated under agreement by the clinic for furnishing services to clinic patients in a location other than the clinic facility. These services are payable only to the RHC. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the RHC for provision of services in a location away from the clinic facility, services provided away from the clinic shall not constitute RHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the RHC, the clinic is required to carve out all expenditure associated with those services on the cost report.
   2. Services in a Hospital: Services provided by a clinic practitioner in outpatient, inpatient, or emergency room of a hospital or in swing-bed do not constitute RHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a clinic practitioner during a time period for which he/she is compensated by the RHC, the clinic must carve out all expenditure associated with these services on the cost report.
   4. Visiting Nurse Services: Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:
      (1) The RHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;
      (2) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;
      (3) the "place of residence" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;
      (4) the services are furnished by a registered nurse (RN) or a licensed practical nurse (LPN) who is employed by or receives compensation from the RHC for providing these services;
      (5) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the clinic. The treatment plan is:
         - reviewed at least every 60 days by a supervising physician, and
         - signed by a supervising physician, ARNP, or PA of the clinic;

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(6) the services consist of:

- nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
- personal care services to the extent covered under home health services. This does not include household & housekeeping services.

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5. Content-of-Service
Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as RHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:
   1. Services furnished by the auxiliary health care staff employed by the clinic that are "incident to" the services provided by the certified health care professionals.
   2. Administration of vaccine, immunization, or other injection. It does not constitute a billable encounter unless it is of a kind which cannot be self-administered.
   3. Lab procedures performed by the auxiliary health care staff employed by the clinic.
   4. Professional component of Radiology or EKG if performed by a clinic health care professional.

6. Drugs & Biologicals That Cannot Be Self-Administered
The only drugs and biologicals covered as rural health clinic core services are those which cannot be self-administered. Administration of these by a clinic personnel may be billed as an encounter.

7. Exclusions
Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of clinic patients are not covered. These should neither be billed as RHC visits nor reported on the cost report as allowable RHC expenditure. In addition, the following are not covered as RHC benefit:
   1. All services furnished by the auxiliary health care staff who are not employed by the clinic.
   2. Services provided by the RHC's auxiliary health care employees without direct supervision of a clinic practitioner.
   3. Technical components of Radiology and EKG.
   4. Health care services performed by outside entities, including those entities which are owned by the clinic's owner or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The state plan requires that providers of these services bill Medicaid directly.

2. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS) for rural health clinics to conform with BIPA 2000. There will be no retroactive cost settlements under this system. As an alternative to the PPS, providers will be offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, RHCs will be paid the greater of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system for the duration of a specific facility fiscal year, providers will be required to submit written requests on a timely basis according to the schedule outlined in II.B below.

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Methods & Standards for Establishing Payment Rates

Rural Health Clinic Services

1. Definitions
   2. Rate - Payment for each qualified encounter or visit.
   3. Base Years or FY 1 & FY 2 - Current Providers - Facility fiscal years 1999 and 2000.
   4. Base Years or FY 1 & FY 2 - New Providers - Two facility fiscal years subsequent to the first year of business as a rural health clinic.
   5. Cost-Based Rate or Payment - Based on the Medicare cost report.
   5. Baseline Rate - Average of cost-based rates from the base years.
   6. MEI - Percentage increase in the Medicare Economic Index for primary care services.
   7. PPS Rate or Payment - Meets PPS requirements outlined in the BIPA 2000.
   8. Non-PPS Rate or Payment - Does not meet BIPA requirements.
   9. Preliminary - Derived from the Medicare cost report for only one base year.
   10. Final or Finalized - Derived from Medicare cost reports for both base years.

B. Criteria for Election of the Alternative Payment Option
   1. For facility Fiscal Years Beginning Prior to October 1, 2001 – The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time
   2. For Facility Fiscal Years Beginning On or After October 1, 2001 – The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
   3. No Request Received - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

3. Cost Reports
   RHC providers shall not be required to submit cost reports to Medicaid. The agency will use finalized cost reports received from Medicare intermediaries.

3. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, rural health clinics shall be paid prospective rates based on an average of the reasonable costs of providing covered RHC services during the base years, with no retroactive settlement.

1. Determination of PPS Baseline Rate
   1. Methodology - It will depend on the time frames covered by and availability of cost reports as follows:
      (1) Both Base Years Full Twelve-Month Periods: (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) / 2.
      (2) One or Both Base Years Less Than Twelve-Month Periods:
      [(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of

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Months

(3) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.

(4) No Base Year Cost Report Available: The lower of current rate (effective on 12/31/ 2000) or average of baseline rates of other RHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce.

2. Frequency - Twice, unless Medicare cost reports for both base years are available at the time of initial rate setting:

(1) Initial Baseline Rate: After the approval of the SPA (for current providers) or at the time of enrollment (for new providers). This rate can be "preliminary" or "final" depending on the availability of cost reports.

(2) Final Baseline Rate: When Medicare cost reports for both base years become available.

B. Payment Procedure for January 1, 2001 to September 30, 2001

2. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/ 2000.
3. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.
4. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
5. In cases where the initial baseline rate is "preliminary", interim payments will again be retroactively reconciled to the "final" baseline rate when it becomes available.

3. Payment Procedure for October 1, 2001 to September 30, 2002

1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
2. In cases where the baseline rate is "preliminary", when the "final" baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

4. Payment Rate Effective Each October 1 After September 30, 2002

1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
2. In cases where the baseline rate used for this rate setting is "preliminary", when the "final" baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

5. Baseline Rate for New Providers

1. If Historic Cost Reports Are Available: If the facility is an established RHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS

baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve-month period. Data covering the first year of business as a RHC will be excluded.

2. If No Historic Cost Reports Are Available: The payment rate shall be the average of the rates paid to other RHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

6. Change in Scope of Services
To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered RHC services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. Any rate change would be implemented on the first of the month following the SRS decision.

4. ALTERNATIVE PAYMENT METHODOLOGY - "MODIFIED COST-BASED SYSTEM"

Interim payments shall be reconciled to the higher of cost-based or PPS-based amount through fiscal year end retroactive cost settlements.

1. Payment Rates Effective January 1, 2001 to September 30, 2001
Prior to HCFA approval of this state plan amendment, Medicaid has continued to pay rates that were effective on December 31, 2000. These will be changed to PPS baseline rates when they are computed (see III.B.2).

2. Payment Rates Effective October 1, 2001 to September 30, 2002
Baseline rates effective on September 30, 2001 times the MEI index.

3. Payment Rates Effective Each October 1 After September 30, 2002
The PPS rates effective on the previous day (September 30 of the same year) adjusted for the MEI index.

4. Retroactive Cost Settlement
   1. Cost-Based Medicaid Cost: It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate from the Medicare cost report to total covered Medicaid visits obtained from the fiscal agent records.
   2. **PPS-Based Medicaid Cost:** It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.

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3. Total Payment Received by Provider: It consists of Medicaid payment, third party liability, and HealthConnect payments obtained from fiscal agent records; and any other related transaction.
4. **Overpayment or (Underpayment)**: The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

5. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a RHC elects the alternative reimbursement option for a given fiscal year, it will be eligible for a settlement on covered services provided during that time period to eligible Medicaid beneficiaries under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the RHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified Cost-Based System (CBS), for the elected fiscal year.

1. Quarterly Supplemental Payments
The RHC shall send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "RHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the RHC no more than 90 days from the receipt of the remittance advices.

2. Fiscal Year End Settlement
When a fiscal year end final cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during the same fiscal year. An "yearly alternative amount" will be computed using total encounters for that time period obtained from the supplemental payment data and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed yearly alternative amount is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the yearly alternative amount is lower than total payments, the RHC shall refund the overpayment to the agency.